Total Cost of Care (TCOC) Workgroup

April 4, 2018

HSCRC
Health Services Cost Review Commission

Agenda

- Introductions
- Updates on initiatives with CMS (including QPP update)
- Update on Y1 MPA implementation
  - Completion of Y1 attribution
  - Option of combined MPA for multiple hospitals
- Discussion of Y2 MPA issues
  - Hospital's changing risk profiles
  - Y2 Maximum Revenue at Risk, Maximum Performance Threshold
  - Attainment
  - Quality adjustment

Updates on Initiatives with CMS

- TCOC Model
- Care Redesign Programs (HCIP, CCIP)

MPA and potential MACRA opportunity

- Under federal MACRA law, clinicians who are linked to an Advanced Alternative Payment Model (APM) Entity and meet other requirements may be Qualifying APM Participants (QPs), qualifying them for:
  - 5% bonus on QPs' Medicare payments for Performance Years through 2022, with payments made two years later (Payment Years through 2024)
  - Annual updates of Medicare Physician Fee Schedule of 0.75% rather than 0.25% for Payment Years 2026+
- Maryland is seeking CMS determination that:
  1. Maryland hospitals are Advanced APM Entities; and
  2. A clinician participating with hospital(s) in Care Redesign Program (HCIP, CCIP) is eligible to be QP based on % of clinician's Medicare beneficiaries or revenue linked to that specific hospital*
- Other pathways to QP status include participation in a risk-bearing Accountable Care Organization (ACO)

* Described on upcoming slides but, in short, via MPA or hospital encounter

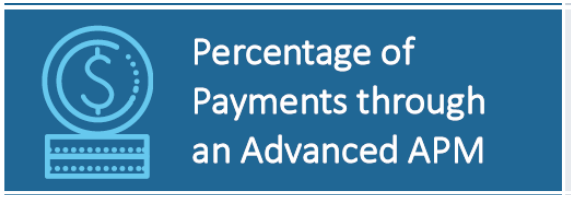
IF CMS approves Maryland hospitals as Advanced APM Entities …

- Clinicians who participate with hospitals in a Care Redesign Program (HCIP, CCIP) would still need to meet the following thresholds to be a Qualifying APM Participant (QP)

Requirements for Incentive Payments for Significant Participation in Advanced APMs (Clinicians must meet payment or patient requirements)						
Performance Year	2017	2018	2019	2020	2021	2022 and later
Percentage of Payments through an Advanced APM	25%	25%	50%	50%	75%	75%
Percentage of Patients through an Advanced APM	20%	20%	35%	35%	50%	50%

* Clinicians must also meet these thresholds to qualify for MACRA incentives in risk-bearing ACOs (e.g., 1+) and other Advanced APMs

Additional details



- What is included in "Percentage of Payments"?
  - Denominator is "aggregate of payments for Medicare Part B covered professional services furnished by" the clinician (42 CFR 414.1435(a))
  - Numerator is the subset of those payments for the beneficiaries linked to the APM Entity
- For most Advanced APMs, CMS calculates QP Threshold Scores based on groups of clinicians. However, for HCIP and CCIP, QP Threshold Scores are calculated for each individual clinician

How QP Threshold Scores might be calculated for clinicians in HCIP and CCIP?

- Care Partner's **denominator**:
  - Based on Medicare beneficiaries with Part A and Part B for whom the clinician had one evaluation and management (E&M) service*
- Care Partner's **numerator**: Among beneficiaries in the Care Partner's denominator, the numerator would be based on those who meet either of the following criteria:
  - (1) Beneficiary is attributed under the MPA algorithm to the specific Maryland Hospital(s) with which the Care Partner participates, or
  - (2) Beneficiary had an encounter (inpatient stay, outpatient encounter) at the specific Maryland Hospital(s) with which the Care Partner participates

* For full requirements, see 42 CFR §414.1305 (e.g., age 18+, US resident)

Another look: QP Threshold Ratio (proposed)

Numerator (subset of those in Denominator)

Clinician's A&B benes linked to hospital where clinician is CRP Care Partner:

(1) Beneficiary attributed to that hospital under MPA or

(2) Beneficiary had encounter at that hospital

Denominator

A&B benes for whom the clinician had an E&M claim

Preliminary modeling of potential QP Threshold Scores

- Analysis among ~15,000 clinicians with 100 benes or $30,000 in Part B claims (for modeling purposes; aligns with CMS MIPS low-volume threshold)
- Assume clinician will be Care Partner with hospital producing highest QP threshold score
- Share of clinicians meeting QP Threshold score (CY17 data):

CY2017	Test	% of clinicans meeting threshold*	Avg qualifying score
2018 test	20% Part B payments or 25% of benes	99%	80%
2019-20 test	35% of Part B payments or 50% of benes	97%	82%
2021+ test	50% of Part B payments or 75% of benes	87%	85%

- Share is similar when modeling actual HCIP Care Partners in 2017 with their partnering hospital

* Actual numbers will be lower when including clinicians' out-of-state beneficiaries. HSCRC analysis based on data only for Maryland Medicare beneficiaries.

Timing for QP status IF CMS approves (1) MD hospitals as Advanced APM Entities and (2) QP calculation

- 3 times a year, CMS looks at whether or not a provider is on a CMS "list" of Advanced APM participants:

- For Maryland clinicians in CCIP and HCIP, the "list" is the Certified Care Partner List sent to CRISP/HSCRC to CMS
- If CMS determines Maryland hospitals are Advanced APM entities, a clinician on a hospital's Certified Care Partner List after the CMS Determination (if applicable, 3/31, 6/30 or 8/31) would have QP Threshold Score assessed
- If CMS Determination in 2018, claims for QP Threshold Score would be from date of CMS Determination through applicable date (3/31, 6/30 or 8/31)
- Qualifying at any one of those 3 dates qualifies for the entire year of CY 2018 participation. QP's MACRA incentive paid in 2020 as 5% of Part B professional claims in all 2018

Final disclaimer

- CMS is continuing to assess the QPP attribution rules
- No decision has been made by CMS
- Nothing is official until CMS announces it

Update on Y1 MPA Implementation

Year 1 attribution implementation: Attribution lists and info

- Beneficiary attribution has been run for base period CY17 and performance period CY18 within Chronic Condition Warehouse
  - ACO-Like Practitioner NPI list provided by ACO Hospitals
    - If Hospital linked Practitioner to a specific hospital then benes are attributed accordingly. Otherwise benes are distributed between all hospitals within the ACO based on Medicare payments
  - Lists soon available by Hospital and Practitioner NPI for both ACO-Like and MDPCP-Like
    - Beneficiary Counts for Calendar Years 2015-2018
    - Total Cost of Care Amounts for Calendar Years 2015-2017
      - 2017 ~99% Complete
  - Attribution programs and ACO-Like NPI lists have been shared with CRISP/hMetrix for Performance Monitoring and Beneficiary Identifiable Data

Option of combined MPA for multiple hospitals for Rate Year 2020

- Permit multiple hospitals, at their option, to be treated as a single hospital for purposes of calculating the MPA, having the same MPA-attributed population.
- Combinations of hospitals must include a regional component and serve a purpose that is enhanced by the combination:
  - System hospitals in the same area (e.g., UMMC, Midtown, UMROI)
  - Non-system hospitals in the same area (e.g., Montgomery County)
- MPA attribution performed for all hospitals individually, then combined for those under combined MPA.
- Identical MPA applies to all hospitals in combination, based on combined MPA population

Letter to CFOs sent 3/14. Replies due 4/18

Y2 MPA Issues: Hospital's changing risk profile YOY in Improvement Only

Reminder from last meeting… Simple Risk Adjustment options

- TCOC per Capita Demographic Adjustment
  - Gender/Age-Band/Dual Status/ESRD Status
    - Normalize TCOC per capita for population change from Base Year to Performance Year based on 66 demographic buckets
    - Removes coding intensity differences between providers, which can occur when using HCC Scores based on diagnoses
- CMS-HCC New Enrollee (NE) Risk Scores
  - Risk Scores published for Medicare Advantage, generally for those without 12 months of claims experience (same buckets as above)
    - Thus, also removes coding intensity differences
    - Normalize TCOC per capita for risk score change from Base Year to Performance Year

Risk Adjustment modeling: Effect on hospitals' improvement

- Modeling approach:
  - Adjust 2015 actual per capita to show what the 2015 per capita would have been with 2016 risk profile
- Focuses on reducing the impact of beneficiary characteristics change within each hospital's population from year to year
  - Does not compare risk profiles between hospitals
- The change in the risk profile from 2015 to 2016, and its modeled effect on the MPA if in place in 2016, does not predict effects in future years
- Policy questions:
  - Is it appropriate to risk adjust for a hospital's changing population year over year?
  - If appropriate, what is the best risk-adjustment methodology?

Simple Risk Adjustment (RA) 2015 to 2016

- MPA Performance statewide based on Y1 Algorithm:

	No RA	RA: Demographic	RA: New Enrollee Risk Score
2015 MPA TCOC per Capita Actual	$11,667	$11,667	$11,667
Risk Adjustment to 2015 MPA TCOC per Capita	0.0	1.001	1.002
2015 MPA TCOC per Capita Adjusted Base	$11,667	$11,674	$11,688
2016 MPA TCOC per Capita Actual	$11,650	$11,650	$11,650
2016 Growth Rate	-0.15%	-0.21%	-0.33%

- Relatively modest adjustments state-wide to the 2016 TCOC per Capita Growth Rate but differences in variation by facility

	No RA	RA: Demographic	RA: New Enrollee Risk Score
Difference from 2016 Actual Growth rate		-0.06%	-0.19%
Largest facility growth rate increase*		4.24% (Midtown)	0.85% (Garrett)
Largest facility growth rate decrease		-2.44% (St. Agnes)	-1.79% (Ft. Wash.)

* Excluding McCready

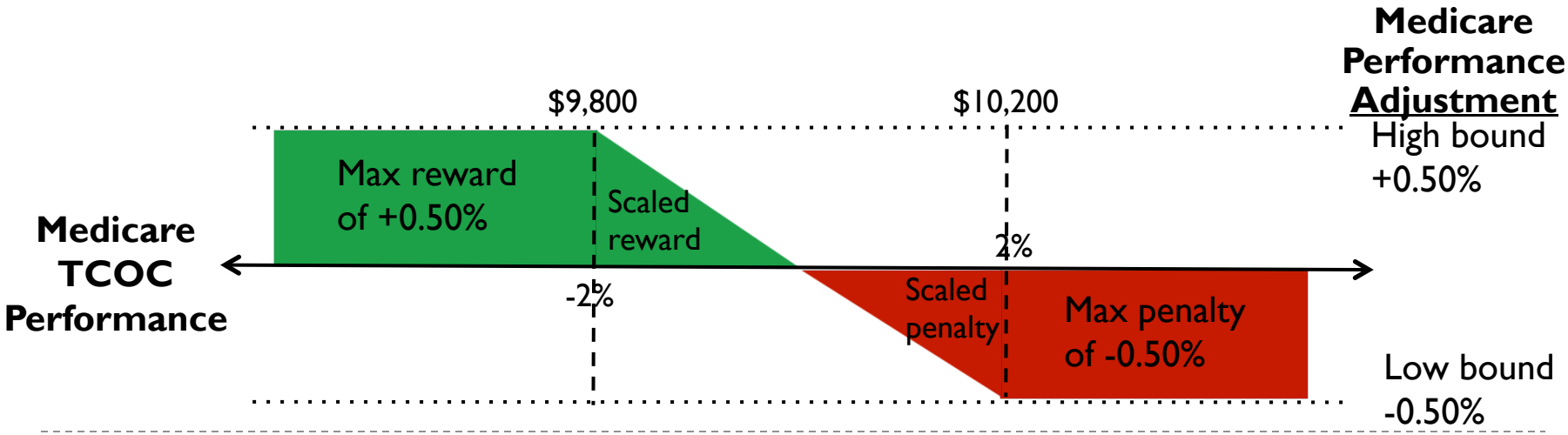
Results if MPA in place in 2016: Improvement Only

STATEWIDE TOTAL	$3,298,803	$3,511,518	$5,118,718				
HOSPITAL	MPA: No Risk adjustment	MPA: Demographic RA	MPA: NE Score RA	HOSPITAL	MPA: No Risk adjustment	MPA: Demographic RA	MPA: NE Score RA
Meritus	($177,391)	($72,446)	($118,475)	Union of Cecil	($59,500)	($48,809)	($21,974)
UMMC	$441,450	$260,166	$259,456	Carroll County	$42,609	($101,012)	$104,262
Prince George's	$5,098	($153,620)	$101,000	MedStar Harbor	($249,055)	($249,055)	($249,055)
Holy Cross Hospital	($171,110)	($82,961)	($159,737)	UM Charles Regional	($157,718)	($126,429)	($88,144)
Frederick Memorial	($328,954)	($100,100)	($289,865)	UM at Easton	$528,981	$528,981	$528,981
Harford Memorial	($39,036)	($29,036)	($22,704)	UMMC Midtown	$258,261	($309,263)	$277,782
Mercy	$514,521	$616,255	$540,955	Calvert Memorial	($61)	($125,624)	($8,272)
Johns Hopkins	$1,926,098	$1,926,098	$1,926,098	Northwest Hospital	$392,740	$330,945	$416,694
Saint Agnes	($614,553)	($300,881)	($614,553)	UMBWMC	$300,855	$516,019	$536,341
Sinai Hospital	($446,304)	$15,835	($190,163)	GBMC	$341,085	$44,218	$276,662
Bon Secours	$113,970	$113,970	$113,970	McCready	$26,406	($26,406)	$26,406
MedStar Franklin Sq	($467,942)	($306,255)	($372,033)	Howard General Hospital	($250,151)	($172,380)	($113,953)
Washington Adventist	$347,564	$162,778	$347,564	Upper Chesapeake	$371,759	$305,215	$347,204
Garrett County	$44,732	($9,002)	$18,299	Doctors' Community	($159,137)	($70,896)	($128,345)
MedStar Montgomery	$250,273	$248,692	$294,776	Greater Laurel Hospital	$141,977	$141,977	$141,977
Peninsula Regional	$121,176	($24,065)	$263,583	MedStar Good Samaritan	($557,199)	($518,615)	($523,302)
Suburban Hospital	$445,000	$445,000	$445,000	Shady Grove Adventist	($58,897)	($35,324)	$85,674
AAMC	($282,066)	($65,934)	($45,440)	Fort Washington	$183	($119)	$56,750
MedStar Union	($80,297)	$72,041	($61,164)	Atlantic General	$150,663	$150,663	$150,663
Western MD	($408,739)	($484,345)	($382,987)	MedStar Southern MD	$339,578	$273,524	$353,673
MedStar Saint Mary's	($66,049)	$19,443	($113,903)	UM Saint Joseph	($63,197)	$7,512	$172,893
Hopkins Bayview	$834,682	$834,682	$834,682	Levindale	($15,568)	($69,080)	($47,597)
UM at Chestertown	$96,759	$67,709	$115,520	Holy Cross Germantown	($84,692)	($88,546)	($66,479)

Y2 MPA Issues: Maximum (Medicare) Revenue at Risk, Maximum Performance Threshold

Year 1 MPA is "improvement only" with 0.5% hospital Medicare revenue at risk

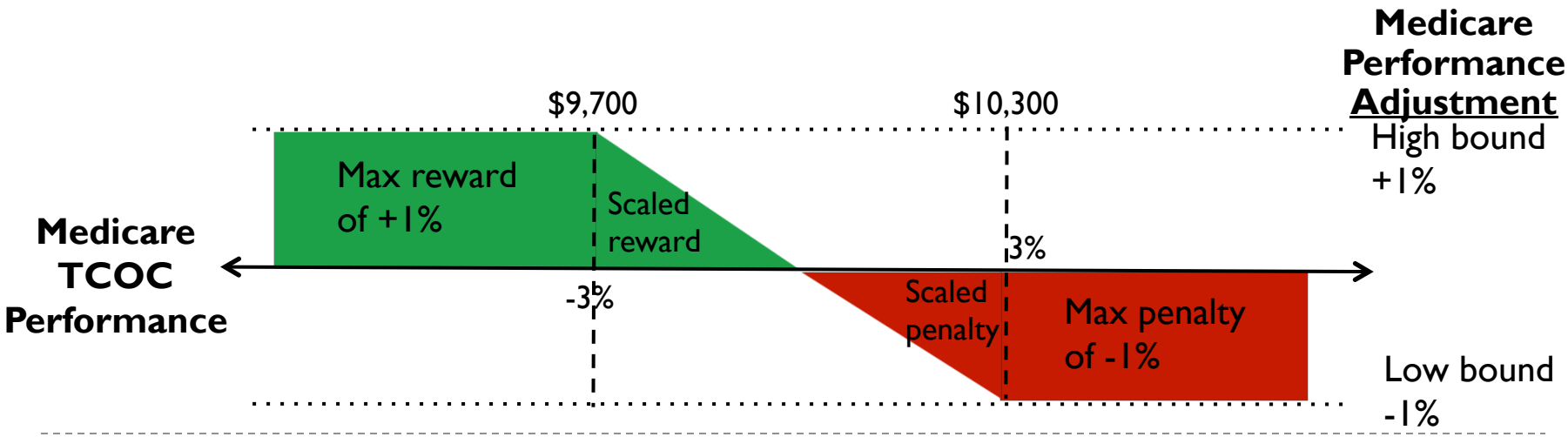
- CY 2017 per capita Medicare TCOC: $9,852
- National Medicare FFS growth in CY 2018 (totally made-up example) = 1.83%
- TCOC Benchmark = $9,852 * (1 + 1.83% - 0.33%) = $10,000
- If CY 2018 per capita TCOC is:
  - $10,200+ (2%+ above Benchmark), then full -0.5% MPA
  - $9,800 or less (2%+ below Benchmark), then full +0.5% MPA
  - Scaled MPA ranging from -0.5% to +0.5% between $9,800 and $10,200



Note: For simplicity's sake, example assumes Quality Adjustment of 0%.

Year 2 MPA: Must increase Medicare revenue at risk to 1%

- Change Maximum Performance Threshold to 3%? (up from 2%)
  - CMS wants ratio of Maximum Revenue at Risk / Maximum Performance Threshold to be at least 30%
  - Y1 ratio is 25% (0.5%/2%)
  - This example for Y2 would be 33% (1%/3%)



Note: For simplicity's sake, example assumes Quality Adjustment of 0%, and dollar amounts in prior slide applied here as well (i.e., updated one year).

Y2 MPA Issues: Attainment possibility

- Options for implementing attainment in MPA calculation
- Hospitals' 2016 attainment levels, with and without risk adjustment

Feds insist that MPA calculation be included in TCOC Contract

- MPA formula, capped at Maximum Revenue at Risk percentage:

$$\frac{\text{TCOC Benchmark} - \text{TCOC Performance}}{\text{TCOC Benchmark}} \times \frac{\text{Maximum Revenue at Risk}}{\text{Maximum Performance Threshold}}$$

- Assume Y2 example just shown, with TCOC Performance of $9,800

$$\frac{\$10{,}000 - \$9{,}800}{\$10{,}000} \times \frac{1\%}{3\%}$$

$$= 2\% \times \frac{1}{3} = +2/3\%$$

Note: For simplicity's sake, example assumes Quality Adjustment of 0%.

How to potentially reflect Attainment in this formula for Year 2?

$$\frac{\text{TCOC Benchmark} - \text{TCOC Performance}}{\text{TCOC Benchmark}} \times \frac{\text{Maximum Revenue at Risk}}{\text{Maximum Performance Threshold}}$$

- Tweak the TCOC Benchmark based on Attainment
- For example:
  - Current TCOC Benchmark calculates previous year TCOC per capita and assumes national growth (made-up as 1.83% in this example) minus 0.33%
    = $9,852 * (1 + 1.83% - 0.33%) = $10,000
  - To reflect Attainment, maybe the hospitals in the lowest quartile of TCOC per capita only have to be 0.17% below national growth for purposes of the MPA
    = $9,852 * (1 + 1.83% - 0.17%) = $10,015

Note: Assumes $9,852 was average TCOC per capita on hospital's attributed population in CY 2018.

If the calculation works and could be approved by Commission, CMS, etc., etc.

- Which hospitals should qualify for the Attainment Adjustment?
  - Like our Readmissions program, should the standard be set based on the prior-year data (then grown at the appropriate rate) at the hospital at the lowest quartile?
  - Should it be upside only?
- What is the appropriate size of the Attainment Adjustment?
- What is the appropriate risk adjustment (and how much does it matter)?

Example: Draft 2016 TCOC per capitas for potential Attainment Adjustment

STATEWIDE TOTAL	$11,650	$11,650	$11,650	LOWEST QUARTILE	$10,609	$10,553	$10,580
HOSPITAL	MPA: No Risk Adjustment (RA)	MPA: Demographic RA	MPA: NE Score RA	HOSPITAL	MPA: No Risk adjustment	MPA: Demographic RA	MPA: NE Score RA
Meritus Medical Center	$10,964	$10,922	$10,720	Union of Cecil	$11,283	$11,280	$11,502
University of Maryland	$12,844	$12,878	$12,708	Carroll County General	$11,240	$11,322	$11,447
Prince George's Hospital Center	$10,827	$10,948	$10,977	MedStar Harbor Hospital	$12,994	$13,149	$12,718
Holy Cross Hospital	$10,062	$10,027	$9,837	UM Charles Regional Medical Center	$10,881	$10,859	$11,277
Frederick Memorial	$10,608	$10,525	$10,986	UM Shore Medical Center at Easton	$11,051	$11,000	$11,001
Harford Memorial	$12,251	$12,244	$12,015	UM Medical Center Midtown Campus	$17,557	$18,313	$15,696
Mercy Medical Center	$13,257	$13,206	$12,802	Calvert Memorial	$10,613	$10,738	$11,066
Johns Hopkins	$13,124	$13,086	$12,859	Northwest Hospital	$12,739	$12,783	$12,486
Saint Agnes Hospital	$13,256	$12,941	$12,696	UM Baltimore Washington Medical Center	$11,922	$11,854	$12,063
Sinai Hospital	$13,897	$13,795	$13,617	Greater Baltimore Medical Center	$11,374	$11,507	$11,556
Bon Secours	$13,905	$14,130	$12,166	McCready	$10,783	$11,757	$9,909
MedStar Franklin Square	$13,480	$13,432	$13,291	Howard General Hospital	$10,501	$10,465	$10,830
Washington Adventist	$11,314	$11,589	$10,967	Upper Chesapeake Medical Center	$10,222	$10,254	$10,859
Garrett County	$8,771	$8,929	$8,587	Doctors' Community Hospital	$12,569	$12,516	$12,710
MedStar Montgomery General	$10,627	$10,635	$10,636	Greater Laurel Hospital	$9,922	$9,899	$10,283
Peninsula Regional	$11,402	$11,461	$11,168	MedStar Good Samaritan	$15,417	$15,286	$14,656
Suburban Hospital	$9,934	$9,950	$9,825	Shady Grove Adventist	$10,189	$10,185	$10,033
Anne Arundel Medical Center	$9,797	$9,752	$10,406	Fort Washington	$8,880	$8,887	$9,469
MedStar Union Memorial	$14,000	$13,949	$13,314	Atlantic General	$9,727	$9,723	$10,092
Western MD Health System	$12,228	$12,272	$11,688	MedStar Southern Maryland	$11,719	$11,767	$12,127
MedStar Saint Mary's Hospital	$11,774	$11,707	$12,065	UM Saint Joseph Medical Center	$11,002	$10,986	$11,297
Johns Hopkins Bayview Acute Care	$13,255	$13,294	$12,870	Levindale	$13,579	$13,665	$13,412
UM Shore Medical Center at Chestertown	$11,570	$11,637	$11,528	Holy Cross Germantown Hospital	$6,382	$6,443	$6,884

Y2 MPA Issue:
Quality Adjustment

MPA Quality Adjustment

- Rationale
  - Payments under an Advanced APM model must have at least some portion at risk for quality
  - Because the MPA connects the hospital model to the physicians for AAPM purposes, the MPA must include a quality adjustment
- Other requirements
  - Must be aligned with measures in the Merit-Based Incentive Payment System (MIPS) to the extent possible

Quality adjustment for Y1

- Use RY19 quality adjustments from Readmission Reduction Incentive Program (RRIP) and Maryland Hospital-Acquired Infections (MHAC).
- Mechanism
  - MPA will be multiplied by the sum of the hospital's quality adjustments
  - For example, a hospital with TCOC scaled reward = 0.3%, then with MHAC quality adjustment =1% and RRIP quality adjustment = 0% would receive an MPA adjustment of 0.303%.

Potential options for quality adjustment for Y2

- Goals
  - Increase focus on population health
  - Align quality adjustment more closely with MPA attribution or geography

- Option: Use existing HSCRC measures, but calculate rates on a per capita basis?
  - Idea to calculate a rate of potentially avoidable hospitalizations among the hospital's attributed population
  - Leverages existing measurement of Prevention Quality Indicators (PQIs) and readmissions but with a population-based denominator based on MPA attribution or geography
    - Community-based denominator not currently available in other HSCRC quality programs

- Option: Test new types of care coordination measures?
  - Idea is to use comprehensive Medicare claims data for measurement in ways not possible using HSCRC's case-mix data alone.
  - For example: follow-ups after hospitalization for specific conditions, etc.

Per Capita measures: Prevention Quality Indicators (PQIs)

- Hospitalizations from ambulatory-care sensitive conditions that may be preventable through effective primary care and care coordination.
- National Quality Forum (NQF) endorsed
- Under consideration for MIPS (panel size concerns on doctor level)
- AHRQ risk adjustment for age and sex*

PQI Composites (v6)	PQI #s included
PQI 90 Overall PQI Composite	All
PQI 91 Acute PQI Composite	Perforated appendix, Dehydration, Pneumonia, Urinary Tract Infections (PQIs 2,10,11,12)
PQI 92 Chronic PQI Composite	Diabetes (See PQI93), COPD/Asthma in older adults, hypertension, heart failure, asthma in younger adults (PQIs 1,3,5,7,8,14-160
PQI 93 Diabetes PQI Composite	Diabetes Short Term Complications, Long-term Complications, Uncontrolled diabetes, lower-extremity amputation (PQIs 1,3,14,16)

*Risk adjustment coefficients for ICD-10 time period are expected to be available in late 2018

Application of quality adjustment

- In year 1, the MPA was calculated by multiplying the TCOC scaled reward by the sum of the quality adjustments for RRIP and MHAC
- If we use measures instead of existing quality adjustments, how to evaluate and apply?

Next meeting:

8:00 a.m. Wednesday, April 25

Total Cost of Care (TCOC) Workgroup

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